



December 9, 1992

Mr. Curtis Clark, Project Director
North Carolina Government Performance Audit
Room 612-Legislative Office Building
Raleigh, NC 27603-5925

Dear Mr. Clark:

As Director of the Equal Opportunity Services Division in the Office of State Personnel, I have been asked by Mr. Lee to respond to the revised draft of Phase I Performance Audit of Personnel Systems as it relates to Equal Opportunity. First, let me say that I appreciate the EEO changes that were made as a result of earlier comments which you received from Mr. Lee.

After review of the revised draft, I make the following recommendations which I believe would enhance the statements on the EEO function and other personnel functions and practices which have an impact on EEO. The recommendations are in two components: I.) my new recommendations and II.) suggested revisions to existing recommendations and other items found in the revised draft. Also, I have provided a rationale for both components:

I. New recommendations

A. Additions to recommendations under the Human Resources Practices

Recommendation 1. The General Assembly should assure funding to adequately address identified weaknesses so that personnel functions not identified as weak would not suffer at the expense of addressing the most significant weaknesses.

Rationale: This would assure that current personnel practices would not degenerate or become weak as we attempt to address significant weakness as identified in the audit.

Recommendation 2. The State needs to emphasize the criticality of EEO as an integral component of all human resource management policies and practices. OSP needs the authority to enforce EEO accountability in the implementation of agency plans and programs.

Rationale: Equal Opportunity is a concept of fairness and equity. This concept is oftentimes strictly interpreted as a hiring function and only applicable to women, minorities and the disabled. The reality is that EEO is a concept of sound management which affects all employees and all personnel functions.

II. Suggested revisions to recommendations in revised draft:

- A. Page E.3 Recommendation number 2**-"To eliminate the perception...."
Recommend that the word "most" be eliminated. Also, eliminate this word on pg.3.30

Mr. Curtis Clark
December 9, 1992
Page 2

Rationale: This term is highly subjective in the hiring and selection process; it usually carries more weight than other factors such as education, training and experience. This extraneous subjective term unfortunately is a barrier which many times works to the detriment of women, minorities and the disabled in the employment arena.

- B. Page E.4 Recommendation number 4 "Continue to monitor protected class"...Recommend adding the following "hiring, promotion, demotion, separation before the word compensation..."

Rationale: This would make the recommendation more consistent with Title VII of the Civil Rights Act which includes all terms and conditions of employment.

- C. Page 2.8 Exhibit 2-4

Recommend that you add Technical Assistance to the Equal Opportunity Services Division.

Rationale: Currently Technical Assistance is a significant activity for the Division.

- D. Page 3.5 Under Human Resource planning aspect add Equal Opportunity as a most important function

Rationale: EEO usually gets overlooked because it is not recognized as a key consideration of many individuals involved in personnel management.

- E. Page 3.6 change the word welfare to "well being"

Rationale: The word welfare has such a negative connotation in our society that it usually retards our ability to act positively.

These recommendations would strengthen EEO in State Government and provide an opportunity for the state to attract and retain a productive workforce which reflects the citizens of the State.

If you have questions regarding any of the above, I can be reached at 733-0205.

Sincerely,



Nellie F. Riley, Director
Equal Opportunity Services

NFR/gbl

c: Richard V. Lee



December 9, 1992

Mr. Curtis Clark, Project Director
Government Performance Audit Committee
Rm 612, Legislative Office Bldg.
Raleigh, N. C.

Dear Mr. Clark:

Richard Lee gave me a copy of the revised draft of the Phase I Personnel System Performance Audit report and asked that I provide you with any comments and/or other suggestions I might have. Given the short time-frame, I will be as brief as possible, recognizing that I might leave out some details requiring discussion later. I agree with you (as mentioned in your Dec. 3, 1992 letter to Mr. Lee) that many of our comments were included in the 2nd draft. However, there are still a few major, and some minor, inaccurate and/or misleading statements in the report, even though we had pointed them out in our response to the first draft. I will cite the items/statements that are inaccurate, and where appropriate will suggest the correct language.

1. Content pages, Finding 6: States "...more classifications than necessary, which is negatively affecting its effectiveness and perceived integrity."

Response: What is the evidence to support such a statement? Our input from managers is that they want more, not less, classifications to improve effectiveness and perceived integrity. (Additional response below on this same issue).

2. P. E.3; last sentence:

Response: Contrary to the statement, the present system does not deter progression of jobs within job families, or retard "legitimate" career growth. Further, if there are excessive layers of middle management, they do not occur because of the classification system. Therefore, those items should be removed from the statement.

3. P. E.4; under Recommendations; paragraphs 1, 2, and 3.

Response: p.1. The accurate recommendation could be: "The State should continue to conduct classification and compensation studies to determine which jobs are paid below, at, or above the competitive market. The State should refine and make more efficient the classification system, and a flexible compensatory system should be developed to allow more effective management of pay and pay delivery. p2. This paragraph should be deleted. I repeat, there is no evidence to support these statements. p3. If this paragraph is to be left in at all, it should read: "Dual career tracks for more occupations, to provide vertical growth options to more employees". (last 2 sentences could stay as they are).

4. P. 2.5; 4th paragraph, last two sentences are inaccurate.

Response: To be accurate, statements should be: "The specifications for each of the job classifications constitute the scale against which descriptions for individual positions are compared. "SPA classifications exist for all types and levels of positions."

5. P. 2.5; last paragraph: Numbers must be wrong, but I cannot determine what they are supposed to show, so I have no way to correct them.

6. P. 3.5; next-to-last paragraph:

Response : (minor error) Should read: "Agencies with position management decentralization authority are only given the authority to classify individual positions."

7. P. 3.18; last sentence:

Response: This is not an accurate statement, but am not sure of the point to be made, so I cannot offer a suggestion. Best to just delete the sentence.

8. P. 3.31; Finding 6: Same incorrect statement as in #1 above

Response: Same as #1 above.

9. P. 3.33; Next-to-last paragraph

Response: This is still ridiculously inaccurate. The State does use the referenced methodology to establish salary ranges. (The only thing we have not yet been able to do is to formally establish multiple salary schedules that reflect what we are actually doing in practice. Have been waiting for staff and, even more, computer time to put multiple schedules in place). I explained to the consultants several times that we have almost 100% of the time been able to have the midpoints of our applied ranges (not always the ranges shown on the current "schedule"), within 5% of the average actual salaries of jobs we have/are studying. We do not use the market maximums to establish applicable salary ranges; we use market maximums only to determine our own maximums.

To be accurate, the paragraph must read something like this: "The State uses this methodology to determine applicable salary ranges. However, since only one formal salary schedule is in place, too many "special entry rates" and complex administrative procedures have to be developed to accommodate the labor market differences among occupational areas. The State probably needs to develop several salary schedules/plans in order to reflect the labor market, and simplify the compensation and payroll processes."

10. P. 3.34; 2nd & 3rd paragraphs

Response: Still do not believe data supports conclusion. If it does, the proposed "career development" plan would have the same actual effect. Only the semantics would be different. Would be best to leave both paragraphs out, to avoid argument.

Mr. Curtis Clark
December 9, 1992
Page -3-

11. P. 3.39; 1st two indented paragraphs beginning "North Carolina"

Response: These seem out of place; they do not fit with the paragraph before and the one after.

11. Pgs. 3.17 (Exhibit 3-7) and 3.42; (Exhibit 3-15):

Response: The legislative-increase data is incorrect, or at least misleading, based on how N.C. records state increases. The cost-of-living and performance increases listed in Exhibit 3-7 were effective July 1, 1990. No additional increases were given in 1991, as implied by the 1991 date on the chart. The graph on p. 3.42 implies a 4% plus 2% increase in 1990 (which is accurate) and an additional 4% plus 2% in 1991 (which is not accurate - no increase was given eff. in 1991).

I will be glad to discuss any of these concerns at your convenience. Thanks for the opportunity for input. There are a lot of good recommendations in the report. I hope most of them can be implemented.

Sincerely



Don W. Huffman, Director
Position Management Division

bw



STATE OF NORTH CAROLINA
THE TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN

September 18, 1992

Mr. Curtis Clark
Director
Government Performance Audit Committee
Legislative Office Bldg, Rm 612
300 North Salisbury St
Raleigh, NC 27603-5925

Dear Mr. Clark:

As you requested, we have reviewed the findings of the draft Phase I Performance Audit of the State Health Plan. Our response to those findings is attached.

We would like to make some corrections to the section providing current information on the Plan. The claims paid for active and retired employees for the fiscal year ending June 30, 1983 was \$95 million, not \$92 million. Also, the actual cost of claims for active and retired employees for the fiscal year ending June 30, 1992 was \$355 million; it appears that the projected amount of \$550 for that same period quoted in the draft included claims for dependents of active and retired employees.

We would also like to express concern over the fact that the audit findings made no mention of the future cost of retiree health benefits. Since it is currently a requirement in the private sector by the Financial Accounting Standards Board to recognize the liability for retiree health costs, it is expected soon to be a requirement of the Governmental Accounting Standards Board for state governments. The Plan's unfunded liability for future retiree benefits was last estimated in 1988 to be \$3.1 billion. The current informal estimated liability in today's dollars is approximately \$3.7 billion. The funding of this liability will present a tremendous budgetary challenge to the General Assembly.

Please feel free to contact me if you require further information.

Sincerely,

David G. DeVries
David G. DeVries
Executive Administrator

attachment

State Health Plan Response to Phase I Performance Audit Findings

Finding 8: The State spends an additional \$30 million for health care costs over what other employers are paying for equivalent services.

The choice of Mutual of Omaha claims experience in North Carolina as a point of comparison to State Health Plan claims experience is questionable since Mutual of Omaha is not one of the larger commercial insurers in the state. Mutual of Omaha covered 10,114 lives and had \$9,917,643 in premiums in North Carolina in 1991, compared to the State Health Plan's 438,000 lives and \$454.7 million in contributions for the same year. Furthermore, it is our understanding that Mutual of Omaha's claims experience includes several types of group health insurance products, including daily indemnity coverage, Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) and other managed care plans. The State Health Plan data for the period under study reflects an indemnity plan with no additional managed care features.

The comparison of average charges per hospital admission (institutional charges), hospital outpatient visit (facility fee), hospital outpatient surgery (physician fee) and office visit for the State Health Plan and Mutual of Omaha's experience is inaccurate, for several reasons. First, it is not reasonable to compare average charges per admission since the particular services provided during each admission varies by diagnosis and severity of illness. Hence, charges for individual line items on a hospital bill would be the appropriate level of analysis. Second, the State Health Plan has typically had richer benefits (until benefit changes effective July 1991) and has an older average member age with a predominance of females than other plans in North Carolina, including Blue Cross' insured business. Older ages and females would tend to drive up the average charge per admission or visit due to more or more intensive services being required. Third, the State Health Plan does not use underwriting in a manner that Mutual of Omaha and other commercial insurers do, with significant restrictions to avoid or limit adverse selection. The Plan accepts all eligible teachers and state employees regardless of their health or risk factors and without any waiting periods whenever they enroll when first eligible.

The State Health Plan average charges cited in the audit report were estimated by applying Mutual of Omaha's admission and visit incidence rates to State Health Plan population, total payments for each service and the overall ratio of payments to charges. A comparison of Mutual of Omaha's admission and visit rates to the State Health Plan's actual admission and visit rates reveals that the State Health Plan's rates and incidences are much higher than those of Mutual of Omaha. The underestimation of number of paid admissions and visits caused the extrapolated average charge per admission and visit to be overstated. For example, a recalculation of estimated State Health Plan 1991 average charges per admission and visit using the auditor's methodology with the exception of using actual State

Health Plan admission and visit rates yields lower average charges than those of Mutual of Omaha, not higher charges. (See Exhibit A for recalculation of 1991 estimated average charges using the auditor's methodology and for actual average charges.)

It is puzzling why the auditor chose to rely upon Mutual of Omaha data's, with all of its limitations, for purposes of comparison and estimation, rather than request actual cost and utilization data for both the State Health Plan and for Blue Cross and Blue Shield of North Carolina (BCBSNC). This information is prepared on an annual basis and is readily available from the State Health Benefits Office.

Furthermore, the Plan benefits from contracts that BCBSNC has with hospitals which provides that the charges to BCBSNC may not exceed the lowest regularly established charges offered to the general public. Therefore, it is not clear how the State could be charged rates that are higher than those charged to private employers or insurers. Additionally, as of July 1, 1992, the State has implemented its own Contracting Hospital Program which provides that the State receive discounts over and above those granted to BCBSNC.

The State Health Plan's Contracting Hospital Program grants preferred provider status to those hospital and psychiatric and substance abuse treatment facilities which grant the Plan a 5% discount on inpatient room and board charges and outpatient charges and an 8% discount on inpatient ancillary charges, or optionally, a fixed charge per service category designed to achieve approximately the same amount of savings. This discount is in addition to the discount that the Plan realizes through its contractual relationship with BCBSNC. Plan members are given an incentive to use preferred hospitals by way of an additional 20% copayment, up to \$5,000 per year, on charges for services provided by non-preferred providers. Practical and political considerations make Preferred Provider Organizations an extremely difficult option for cost containment. Plan membership is dispersed throughout the state. Many areas have limited physician availability and few have truly competitive hospital options.

The current Contracting Hospital Program is for the current biennium and will expire on June 30, 1993. The Plan will begin meeting in October, 1992 with a hospital task force in order to develop a long-term approach to limiting the rate of increase in charges for hospital services. Attention should first be given to hospital charges before consideration is given to contracting arrangements with physicians or other providers. The Plan currently participates in the BCBSNC CostWise Program which reduces physician charges.

Finding 9: The State has a limited program to prevent catastrophic illness, which is not structured to achieve substantial cost savings.

The Plan has been exploring the possibility of adding a prenatal program designed to identify and manage high-risk pregnancies and a case management program for other expensive and long-term illnesses and conditions. These benefit changes would need approval from the General Assembly before they

could be implemented. Savings from preventive and other wellness benefits have not yet been consistently documented and are likely to be well in the future rather than near-term. Therefore, any estimate of savings from such program should be very conservative. Annual savings of \$150,000,000 or some 20% of current claims cost do not appear to be very conservative in this regard. Furthermore, the Joint Select Legislative Committee on Health Insurance already has these items (see Exhibit C for memorandum) under consideration as indicated by the memorandum of March 23 from Mr. Sam Byrd.

Finding 10: Employees and retirees are dropping dependent coverage under the indemnity plan, which threatens the viability of the medical plan.

While the erosion of membership by dependents does threaten the viability of coverage for dependents, it does not threaten the viability of coverage for active and retired employees and teachers. Despite substantial increases in the contribution rates for dependent coverage which went into effect October 1, 1991, only 3.2% of dependents are estimated to have been dropped from coverage. However, the self-funded indemnity plan experienced dependent disenrollments of 9%, meaning that 5.8% of State Plan dependents switched to HMO coverage during the annual enrollment period for the 1991-92 fiscal year.

Most of the Plan's loss of dependents occurred within the active dependent population; 9.9% of actives' dependents left the self-funded plan, with 6.4% switching to HMO coverage and 3.5% dropping coverage entirely, while only 0.5% of retirees' dependents left the self-funded plan. (Dependents of retirees under HMO coverage increased by an amount which more than offset the self-funded plan's loss, with total dependents of retirees across all plans increasing by 0.2%.) (An analysis of enrollment changes for the fiscal years ending June of 1988 through 1991 is presented in Exhibit B.) The self-funded plan is compensated by HMOs for its loss of members who are better risks to HMOs by way of a monthly risk adjustment fee. This fee is paid to the Plan each month and is calculated based on enrollees' age, with a higher fee paid to the Plan for younger members and a lesser or no fee paid for older members.

The problem of adverse selection growing as premiums rise was addressed by Mr. Sam Byrd of the Office of Fiscal Research in his memorandum to the Joint Select Legislative Committee on State Health Insurance dated February 20, 1992. (See Exhibit D for memorandum.)

Finding 11: The State's benefits program lacks a comprehensive design that allows it to be tailored to employees' needs.

The experience of employers offering fully flexible benefits has shown that adverse selection occurs between plans. That is, employees tend to choose those benefits that they expect to use during a given year. The ensuing high rate of utilization drives up the average cost per person for each component benefit. Since flexible benefit plans are designed to cap employer costs, employees would be left with an increasingly large share of

total contributions for their own coverage each year (unless the State continued to absorb large increases in benefit expenses) and increasing dependent contributions. Health, disability and death benefits under a flexible benefit program when such benefits are currently self funded and administered by the state, would appear somewhat questionable in that the state would in effect be in competition with itself.

Finding 12: The current contribution rates circumvent the intent of the law.

The Plan does set dependent contribution rates at a level which fully funds dependent claims. However, since costs continue to rise, dependent coverage will show a loss during any period, with an attempt to make up the loss by adjusting rates for the upcoming period. The employer and employee rates which went into effect October 1, 1991 were adjusted to bring the contribution rates for dependents back into alignment with dependents' claims experience. This is the reason for a higher rate increase for employee contributions than for employer contributions. The State's contribution rate for employee/retiree coverage increased by 34% while employee contribution rates for child(ren) and family coverage increased by 38% and 42%, respectively.

Since contribution rates are set for each biennium, a surplus of contributions is created during the first year and is depleted during the second year when contribution rates remain the same and are less than what is required to pay claims.

COMPARISON OF NC STATE HEALTH PLAN & MUTUAL OF OMAHA AVERAGE CHARGE PER ADMISSION AND PER VISIT

	Y/E 6/88	Y/E 6/89	Y/E 6/90	Y/E 6/91	
<hr/>					
Enrollment:					
SHP Actives	159,675	188,351	202,189	207,895	
SHP Dependents of Actives	111,050	129,599	137,356	141,376	
Total	270,725	317,950	339,545	349,271	
<hr/>					
Inpatient Hospital (Institutional) Charges					
<hr/>					
MOO Admissions/1,000	60.2	56.0	63.9	61.7	
MOO Charge/Admission (Institutional)	\$3,849	\$5,337	\$5,957	\$7,443	
SHP Admissions/1,000 (Actives + Dep.)	77.4	73.1	72.7	72.0	
SHP Paid Claims	\$77,575,000	\$104,744,000	\$131,744,000	\$154,396,000	
SHP Payments as % of Charges	0.7904332	0.79617041	0.81705814	0.834122	
SHP Charges (Institutional)	\$98,142,386	\$131,559,775	\$161,241,892	\$185,100,021	
SHP Estimated Admissions	20,954	23,242	24,685	25,148	
SHP Estimated Charge/Admission	\$4,684	\$5,660	\$6,532	\$7,360	
SHP Est. Avg. Charge as % MOO Avg. Charge	121.6863%	106.0602%	109.6522%	98.8906%	<-----
SHP Actual Institutional Charge/Admission	\$4,096	\$4,960	\$5,612	\$6,506	
SHP Actual Charge as % of MOO Average Charge	106.4173%	92.9361%	94.2085%	87.4110%	<-----
<hr/>					
Outpatient Hospital (Institutional) Charges					
<hr/>					
MOO Visits/1,000	344.40	339.15	332.85	428.40	
MOO Charge/Visit (Institutional)	\$304	\$329	\$353	\$417	
SHP Visits/1,000 (Actives + Dep.) - Outpt.	315.6	316.5	342.0	374.6	
SHP Visits/1,000 (Actives + Dep.) - E/R	164.7	172.7	175.3	172.2	
SHP Paid Claims	\$19,899,000	\$29,640,000	\$42,439,000	\$55,726,000	
SHP Payments as % of Charges	0.7904332	0.79617041	0.81705814	0.834122	
SHP Charges (Institutional)	\$25,174,803	\$37,228,211	\$51,941,224	\$66,807,973	
SHP Estimated Visits	130,029	155,541	175,646	190,981	
SHP Estimated Charge/Visit	\$194	\$239	\$296	\$350	
SHP Est. Avg. Charge as % MOO Average Charge	63.6872%	72.7497%	83.7721%	83.8884%	<-----
SHP Actual Inst. & Professional Charge/Visit	\$333	\$402	\$470	\$533	
SHP Actual Charge as % of MOO Average Charge	*	*	*	*	<-----

* Charges are not comparable since SHP actual average charges include professional and facility fees and Mutual of Omaha average charges appear to be for facility fees only.

A.19

COMPARISON OF NC STATE HEALTH PLAN & MUTUAL OF OMAHA AVERAGE CHARGE PER ADMISSION AND PER VISIT

	Y/E 6/88	Y/E 6/89	Y/E 6/90	Y/E 6/91	
Enrollment:					
SHP Actives	159,675	188,351	202,189	207,895	
SHP Dependents of Actives	111,050	129,599	137,356	141,376	
Total	270,725	317,950	339,545	349,271	
Outpatient Surgical Charges					
M00 Visits/1,000			46.2	63.0	
M00 Charge/Visit (Institutional)			\$609	\$522	
SHP Visits/1,000 (Actives + Dep.)			11.9	13.3	
SHP Paid Claims			\$11,376,118	\$15,194,152	
SHP Payments as % of Charges			0.81705814	0.834122	
SHP Charges (Professional Fees)			\$13,923,266	\$18,215,743	
SHP Estimated Visits			4,041	4,645	
SHP Estimated Charge/Visit			\$3,446	\$3,922	
SHP Est. Avg. Charge as % M00 Average Charge			*	*	<-----
SHP Actual Professional Charge/Visit			\$1,710	\$1,919	
SHP Actual Charge as % of M00 Average Charge			**	**	<-----
* Charges are not comparable since SHP charges are for surgeon fees and Mutual of Omaha average charges appear to be for facility fees.					
** Charges are not comparable since SHP actual average charges include professional and facility fees and Mutual of Omaha average charges appear to be for facility fees only.					
Office Visit Charges (Includes Fees for Office Visits, Office Surgery, Laboratory, Radiology & Chiropractic)					
M00 Visits/1,000			1,722.0	1,936.2	
M00 Charge/Visit			\$70	\$75	
SHP Visits/1,000 (Actives + Dep.)			3,341.3	3,535.0	
SHP Paid Claims			\$50,368,519	\$58,417,748	
SHP Payments as % of Charges			0.81705814	0.834122	
SHP Charges			\$61,646,187	\$70,035,016	
SHP Estimated Visits			1,134,522	1,234,673	
SHP Estimated Charge/Visit			\$54	\$57	
SHP Est. Avg. Charge as % M00 Average Charge			77.6239%	75.6314%	<-----
SHP Actual Charge/Visit			\$65	\$69	
SHP Actual Charge as % of M00 Average Charge			92.8571%	92.0000%	<-----

A.20

Prepared 2-20-92

NC COMPREHENSIVE MAJOR MEDICAL PLAN
Analysis of Self Funded Plan & HMO Enrollment

	Change From Previous Year				Change From Previous Year				Change From Previous Year			
	12/31/88	12/31/89	\$	%	12/31/90	\$	%	12/31/91	\$	%		
Self Funded Plan												
Active												
Employees	197,375	202,710	5,335	2.7%	209,134	6,424	3.2%	200,647	(8,487)	-4.1%		
Dependents	137,740	138,349	609	0.4%	142,316	3,967	2.9%	128,293	(14,023)	-9.9%		
Retired												
Employees	62,043	64,651	2,608	4.2%	67,652	3,001	4.6%	69,826	2,174	3.2%		
Dependents	14,473	14,392	(81)	-0.6%	14,271	(121)	-0.8%	14,203	(68)	-0.5%		
Continuation												
Employees	1,259	1,534	275	21.8%	2,008	474	30.9%	2,134	126	6.3%		
Dependents	674	853	179	26.6%	1,015	162	19.0%	949	(66)	-6.5%		
Total												
Employees	260,677	268,895	8,218	3.2%	278,794	9,899	3.7%	272,607	(6,187)	-2.2%		
Dependents	152,887	153,594	707	0.5%	157,602	4,008	2.6%	143,445	(14,157)	-9.0%		
HMOs (All Options)												
Active												
Employees	18,754	19,002	248	1.3%	16,499	(2,503)	-13.2%	26,903	10,404	63.1%		
Dependents	13,526	14,155	629	4.7%	12,280	(1,875)	-13.2%	20,945	8,665	70.6%		
Retired												
Employees	1,041	1,216	175	16.8%	1,267	51	4.2%	1,662	395	31.2%		
Dependents	309	341	32	10.4%	329	(12)	-3.5%	433	104	31.6%		
Continuation												
Employees	68	118	50	73.5%	138	20	16.9%	137	(1)	-0.7%		
Dependents	45	98	53	117.8%	102	4	4.1%	86	(16)	-15.7%		
Total												
Employees	19,863	20,336	473	2.4%	17,904	(2,432)	-12.0%	28,702	10,798	60.3%		
Dependents	13,880	14,594	714	5.1%	12,711	(1,883)	-12.9%	21,464	8,753	68.9%		
Self Funded & HMOs												
Active												
Employees	216,129	221,712	5,583	2.6%	225,633	3,921	1.8%	227,550	1,917	0.8%		
Dependents	151,266	152,504	1,238	0.8%	154,596	2,092	1.4%	149,238	(5,358)	-3.5%		
Retired												
Employees	63,084	65,867	2,783	4.4%	68,919	3,052	4.6%	71,488	2,569	3.7%		
Dependents	14,782	14,733	(49)	-0.3%	14,600	(133)	-0.9%	14,636	36	0.2%		
Continuation												
Employees	1,327	1,652	325	24.5%	2,146	494	29.9%	2,271	125	5.8%		
Dependents	719	951	232	32.3%	1,117	166	17.5%	1,035	(82)	-7.3%		
Total												
Employees	280,540	289,231	8,691	3.1%	296,698	7,467	2.6%	301,309	4,611	1.6%		
Dependents	166,767	168,188	1,421	0.9%	170,313	2,125	1.3%	164,909	(5,404)	-3.2%		



North Carolina General Assembly

Legislative Services Office
Legislative Office Building
300 N. Salisbury Street, Raleigh, N. C. 27603-5925

Exhibit C Page 1

GEORGE R. HALL, JR., Legislative Administrative Officer
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March 23, 1992

MEMORANDUM

To: Joint Select Legislative Committee
on State Health Insurance

From: Sam Byrd
Fiscal Research Division *Sam*

Subject: Additional Cost Containment Options for the State
Employee Health Benefit Plan

At your last meeting on February 26, 1992, we, as fiscal staff to the Committee, were asked to gather suggestions from various groups for further cost containment options that could be considered for the State Employee Health Plan. In response to this direction, we contacted thirty-three organizations that we knew were concerned with health care cost containment issues. A listing of these organizations is attached for your review. So far, these organizations have suggested that the following new cost containment options be considered for the Plan:

- (1) Alcohol and Drug Abuse Case Management
- (2) High-Risk Maternity Identification and Case Management
- (3) Case Management for High Cost Treatments (Accidents, Trauma, etc.)
- (4) Wellness and Consumer Health Education Programs for All Employers
- (5) Employee Assistance Program (EAP) for All Employers
- (6) Concurrent Hospital Review and Discharge Planning Program
- (7) Pre-Certification Program for Hospital Outpatient and Ambulatory Surgical Facility Admissions
- (8) Mail Order Pharmacy Program
- (9) Managed Care Provider Networks for High Cost Treatments
- (10) Point-of-Service Preferred Provider Networks (PPOs) for Professional Providers
- (11) Limiting Claim Payments to Professional and Institutional Practice Guidelines based upon Outcomes Research on Cost-Effective Medical Procedures



March 23, 1992
Page 2

- (12) Indexing of Deductibles and Copayments to Medical Component of Consumer Price Index
- (13) Pre-Admission Hospital Testing Program Subjected to Deductibles and Copayments
- (14) Sharing of Erroneous and Fraudulent Professional and Institutional Bill Savings Identified by Plan Members with Individual Members
- (15) Employee Premium Cost-Sharing

It is interesting to note that some of the business and health coalitions within North Carolina refused to offer any suggestions because of their individual member "work capacity" or because of an insufficient amount of time to respond adequately. Another such coalition suggested that the State Employee Plan reconsider its previous cost containment actions because of cost-shifting to other employers and their health care cost payers.

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